June 1, 2011

Ms. Teri Lesh
Office of Medi-Cal Procurement
Department of Health Care Services
State of California
P.O. Box 997413
Sacramento, CA 95899-7413

Via email to omcprfp9@dhcs.ca.gov

Re: Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare

Dear Ms. Lesh:

On behalf of Amerigroup Corporation, I am pleased to submit the following response to the Department's *Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare* dated April 29, 2011. We applaud the Department on taking this significant step toward improving the integration of Medi-Cal and Medicare services for this group of special needs individuals.

Amerigroup and its affiliated health plans serve over 1.9 million beneficiaries of public programs in eleven states through the Medicaid and Child Health Insurance Programs. We also serve Medicare/Medicaid dually eligible beneficiaries through Medicare special needs plans operating in seven states.

We look forward to having an opportunity to work with the State of California as the dual eligible pilot programs unfold. Please feel free to contact me if you have any questions or would like additional information. My direct telephone is (757) 962-6406 and my email address is rjones3@amerigroupcorp.com.

Sincerely,

Rhys W. Jones, MPH
Vice President, Medicare Policy and Market Development

Cc: Patrick Blair, Chief Marketing Officer, Amerigroup
Aileen McCormick, Western Regional CEO, Amerigroup
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California Department of Health Care Services
Response to RFI – Models for Serving Dual Eligibles
Submitted by Amerigroup Corporation

Part 2: Questions for Interested Parties (including potential contracted entities)

1. What is the best enrollment model for this program?

Response: Amerigroup supports the concept of a fully integrated system of care for dual eligibles, and we believe that an integrated system starts with the enrollment process. The enrollment model should ensure that enrollment is seamless: beneficiaries should be able to complete both the Medi-Cal and Medicare plan enrollments at the same time in a single integrated enrollment session with completion of a single enrollment application. Beneficiaries should be able to use information from one comparison chart to select their health plans. Beneficiaries should have one ID Card to access benefits and services under both the Medi-Cal and Medicare programs. A unified new member packet would include a single integrated member handbook for benefits and an integrated provider directory.

Aligned enrollment is a foundational policy issue. We believe that aligned or simultaneous enrollment in Medi-Cal and Medicare managed care should be mandatory for dual eligibles to optimize the potential for care coordination. For the dual eligible SPD population, we recommend that the State of California require individuals to enroll *with the same organization for both their Medicare and Medi-Cal benefits,* if they are enrolled in a Medicare Advantage (MA) plan. This "aligned enrollment" requirement will enable managed care organizations to coordinate their members' Medicare, prescription drug, Medi-Cal and long term care benefits and services more effectively and is more likely to accomplish the cost and quality outcomes sought by the Department of Health Care Services (DHCS) in this program.

For dual eligibles not enrolled in an MA plan (i.e., receiving Medicare benefits in the fee-for-service environment), a MCO's ability to coordinate care is not eliminated but it is significantly diminished. In the context of this demonstration and CMS' enhanced waiver authority, we suggest that the State ask CMS to permit the State to mandate dual eligibles enrollment in Medicare Advantage plans for purposes of this initiative. Federal policymakers have traditionally been opposed to mandating Medicare beneficiaries into Medicare managed care plans; but if successful, such a policy would maximize alignment and contribute greatly to effective care management and coordination. Including an enrollment opt-out provision might make the policy acceptable to federal authorities. Enrollment materials should clearly describe the ability to opt out so beneficiaries or their representatives can make informed decisions on their enrollment choices.

While there are several enrollment service models that could serve beneficiaries, the current model in which California Health Care Options (CHCO) facilitates enrollments for Medi-Cal members provides a good starting point. CHCO appears to be effective both in terms of execution and beneficiary education; it is also a system with which beneficiaries are familiar. The enrollment process could be administered solely by CHCO or be supplemented by direct enrollments conducted by participating managed care organizations (MCOs) using state-approved processes and forms. The DHCS could support program access by allowing enrollment through a number of channels, including enrollments through local county social services offices, by telephone, online or by mail. This would ensure ease of enrollment for beneficiaries with limited access to transportation and/or technology.

At roll-out, the State should organize enrollment events, promotional mailings and educational forums for beneficiaries to learn about the program, their health plan choices and how the enrollment process will work. The State should consider using a phased-in approach to the mandatory enrollment starting with voluntary enrollment that gives beneficiaries several months to make a choice and enroll. It will be important for the dual eligibles to receive assistance from the enrollment administrator to find a plan that includes their providers since many of these individuals will have doctors, specialists, and long term services providers that they want to keep using. We encourage the state to give dual beneficiaries a reasonable amount of time to select a health plan and then, if they have still not chosen a plan, they would be auto-assigned into a plan based on geography and participation of the providers they have used historically.

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

Response: We believe that an integrated model for dual eligibles will be most effective and provide the best outcomes when the model comprises the full range of Medicare and Medi-Cal covered services. The table below illustrates the division of funding responsibility across programs.

Medicare Funded	Medi-Cal Funded	Other; Funding TBD
Acute health services, including: • Hospital inpatient • Hospital outpatient • Behavioral health inpatient • Behavioral health outpatient • Skilled nursing • Rehab therapies • Outpatient diagnostic • Laboratory • Professional services • Ambulance • Emergency room • Home health • Hospice (through FFS) • Transplant services • Pharmacy (Part D)	Long term services and supports, including: • Adaptive aids • Adult foster care • Assisted living/ residential care • Personal emergency response system • Medical supplies • Home modifications • Nursing services • Home therapy • Respite care • Personal assistance services • Day activity health • Long term nursing facility • Non-Part D medications	• Service coordination • Non-emergency transportation • Routine dental • Weight loss programs • Smoking cessation • Financial counseling

3. How should behavioral health services be included in the integrated model?

Response: Amerigroup's experience with dual eligibles over many years validates that both segments of the duals population – seniors and persons with disabilities – have higher rates of co-morbid physical and behavioral health conditions. We believe strongly that integration of physical and behavioral health services is a cornerstone of any program designed to manage this population effectively.

In state procurements for MCO participation in an integrated program for dual eligibles, we recommend that the DHCS evaluate applicants in part based on their ability to integrate physical and behavioral

health in day-to-day care management. Successful MCOs should have in-house behavioral health expertise. They should have experience with an integrated case management model based on predictive modeling and risk stratification of both medical and behavioral conditions that combines physical and behavioral health data into ongoing care management. Other desirable capabilities include co-rounding with both psychiatrists and physical health physicians; and training and coordination programs that pair primary care practitioners and behavioral health clinicians. These kinds of capabilities ensure a truly integrated approach that can optimize treatment and promote continuity of care.

It is key for optimal clinical outcomes to manage the individual person, not just their primary medical condition. An integrated program that recognizes how behavioral, social and functional challenges can compromise an individual's overall health status (especially in low-income populations) is key to delivering improved health outcomes to this population.

4. If you are a provider of long-term services and supports, how would you propose participating in an integration pilot? What aspects of your current contract and reimbursement arrangement would you want to keep intact, and what could be altered in order to serve as a subcontractor for the contracted entities?

Response: Though Amerigroup is not a long-term services and supports (LTSS) provider, we have significant experience working with such providers in many states. We think the integrated duals program envisioned by the State of California would benefit by taking measures to ensure a smooth transition and ensure the ongoing participation of LTSS providers in the program. We recommend that the DHCS initially maintain reimbursement levels for LTSS providers as the program transitions to a managed environment. The DHCS could further support the transition by issuing claims filing standards that all contracted entities would use so that the LTSS providers would not have to change their billing practices to accommodate different contracted MCOs.

Contracted MCOs and LTSS providers should work in partnership to ensure ongoing communication and exchange feedback on members' status and progress. In many cases, members receive services from LTSS providers on a weekly basis and the providers can give input to MCO care managers on a member's condition and set up an alert notification if the member shows signs of deterioration.

Over the long term, the DHCS might consider working with LTSS providers and contracted MCOs to move toward integrating some of the services covered both by Medi-Cal and Medicare, such as skilled nursing services and rehabilitation therapies. Some of these services are now defined and reimbursed differently across the two programs. In an integrated program, such services could be given a common definition and reimbursement that would help streamline administration for both MCs and providers.

5. Which services do you consider to be essential to a model of integrated care for duals?

Response: The spectrum of essential services includes medical, pharmacy, behavioral and LTSS. The MCO care manager needs information from acute inpatient providers regarding member discharge instructions and plan of care. Alerted to a potential nursing home placement, the care manager often can implement a range of services from among the member's medical, transitional and LTSS benefits to care for the member in the community and avoid institutionalization. With information from an LTSS provider that a member is experiencing problems with a service or medication, the care manager can act to resolve the issue and avoid a potential hospitalization. As we noted in our response to Section 1,

these examples underscore the argument that dual eligible members need to receive their Medicare and Medi-Cal benefits from the same MCO.

6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?

Response: A strong education and outreach plan is critical to the success of an integrated program for dual eligibles. This integrated program will involve new ways of delivering services for this population, so the State should plan to prepare the various stakeholders using a variety of education methods and forums. The State should evaluate "lessons learned" from its experience implementing the "Bridge to Reform" 1115 Waiver and incorporate these lessons into the overall outreach plan.

As suggested in our response in Section 1, the DHCS should publicize the program to beneficiaries through a number of channels, including local county social services offices, newspapers and radio, online web-based information and direct mail prior to implementation; all media should promote the program in a variety of languages. This multi-channel approach will help ensure that information reaches beneficiaries with limited access to transportation and/or technology. At roll-out, the State should organize informational and enrollment events, promotional mailings and educational forums for beneficiaries to learn about the program, their health plan choices and how the enrollment process will work.

In each county in the program service area, the DHCS should identify key stakeholders and hold meetings to educate and explain to them how the program will work. This will allow the agency to present its vision for the program and permit stakeholders to ask questions and get answers from agency officials. The DHCS should place special emphasis on provider meetings to educate the various provider groups, including doctors, hospitals, home health providers, nursing facilities and community based long-term care and IHSS/LTSS providers. The agency should also have town hall meetings to inform beneficiaries, consumer advocacy groups and organizations about the new program and how to enroll.

We recommend that the State continue stakeholder meetings through the first year of the program to ensure ongoing communications and education, as well as to give stakeholders and interested parties an opportunity to provide feedback. It may even be helpful to establish regional advisory committees that would perform this function through a formalized structure. Ongoing community and stakeholder engagement will be important to program's success and in keeping constituents informed on progress. The DHCS also should consider contracting with community-based organizations to assist and supplement its community outreach and educational efforts. Such groups would include area agencies on aging, the Centers for Independent Living and California Health Advocates.

7. What questions would you want a potential contractor to address in response to a Request for Proposals?

Response: DHCS should seek qualified and experienced contractors for this integrated program. It is important that RFP respondents demonstrate a comprehensive understanding of the health and service support challenges that are prevalent in the dually eligible population. Potential MCOs should also demonstrate their capabilities to administer the program effectively, including tools, processes and systems that support integration of care and services and measurement of program results. Finally, and most importantly, respondents should demonstrate broad experience with and understanding of

various avenues and strategies to engage with a wide variety of stakeholders during the program implementation process to assure effective buy-in and success of the program over the long-term. Following are recommended questions in key program areas that will assist DHCS in evaluating the qualifications of MCO respondents:

A. Experience

Describe the background and experience of your organization (or your parent organization and affiliates with relevant experience) in working with dually eligible populations. Your response should address the following areas:

1. List the contracts that included dually eligible members and describe the scope of services, contract duration and any special program requirements.
2. Provide an overview of your experience in launching new programs with populations who are new to managed models of care.
3. Describe your experience with, and general approach to, providing services to adults with special health care needs including how you will periodically assess Members needs for services.
4. Describe your experience managing 1915 b/c waiver services for seniors and people with disabilities. What are the key elements of your model which will assure integration of services without duplication?
5. Describe your experience managing "wrap-around" services for dually eligible members.

B. Tools, Processes & Systems

1. Describe your service coordination process, including the tools and systems that support the effective and efficient management of services.
2. Describe your process to assure that members receive quality services. Describe your ability to track, monitor and resolve member complaints.
3. Describe the methods your organization uses to coordinate physical, behavioral, pharmacy and long-term services and supports and how your care management processes integrate communication and feedback from service providers.

C. Engaging Stakeholders

1. Describe your program implementation process. How will you assist members and providers in navigating new models of care and service delivery?
2. Describe your process to assure effective and seamless continuity of services during the transition period.

8. Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries?

Response: Prior to enrolling members, DHCS should conduct a MCO readiness review focused on the capabilities of contracting MCOs to assure seamless implementation of the program and avoid disruption in the delivery of services for member. The readiness review should be scheduled at least several months following the contract award date, allowing MCOs adequate time to implement

standards and finalize development of their provider networks. The DHCS should consider including the following requirements and standards in its readiness review:

1. Review compliance with requirements for network adequacy. MCO networks should show a diversity of providers geographically, culturally and across the spectrum of provider type(s).
2. Examine components of responsive and culturally competent customer service, such as minimum wait time, linguistic capabilities and maximum time frames for resolution of complaints and inquiries. Contractors should demonstrate knowledge of alternative formats and mechanisms to accommodate persons with disabilities.
3. Review contracting MCOs' quality programs to ensure appropriate measures for quality of services and supports on a functional basis. Quality programs should also address monitoring of providers who are unique to programs serving seniors and persons with disabilities, such as those delivering LTSS waiver, social and other non-clinical services.
4. Evaluate MCOs' systems, processes and tools for utilization, medical and disease management.
5. Verify that participating MCOs have integrated systems whenever possible for member enrollment, member complaints, appeals, and grievances.
6. Review care management models and systems to confirm that contractors have models of care that include the following elements:
    - **Initial Assessments** should involve standardized, electronic, comprehensive assessments of the individual's goals; capacities; physical, cognitive, social, environmental and behavioral health conditions; and needs and strengths of the individual, family and/or caregiver.
    - **Comprehensive Service Plans** should meet needs and goals identified by the member. Processes should include input from members, family, caregivers, legal guardians and formal providers to define and authorize necessary services. Service plans include both natural supports and contracted providers.
    - **Episodic and Scheduled Reassessments** of the client's status to determine whether his or her situation and functioning have changed in relation to the goals established in initial service plans.
    - **Service Coordination:** Service coordination is the central, ongoing coordination of the diverse aspects of a member's care throughout the acute and post-acute healthcare continuum to achieve the highest quality and most cost-effective outcomes. Service coordination engages families in development of a service plan and links them to other health and/or services that address the full range of their needs and concerns.
    - **Transitional Care Management:** Transitional care management is the organized system of service coordination that ensures the coordination and continuity of healthcare as members transfer between different locations or different levels of care within the same location.

With respect to schedules for MCOs' development of their contracted provider networks, we understand that DHCS will require fully-contracted network by the time of program implementation. As a Medicaid-focused company, we have significant experience in rapidly building provider networks to meet state requirements. However, our experience as a new entrant in other states indicates that providers are often reluctant to sign contracts or complete credentialing with an MCO until they have

assurances that the MCO has been awarded a state Medicaid contract. Therefore, we recommend that DHCS give provider contracts and Letters of Intent equal weight in evaluating MCO proposals.

Given the proposed timing of the anticipated RFP for this program, if DHCS requires provider contracts at the time of proposal or gives contracts greater weight than Letters of Intent in scoring proposals, this could preclude non-incumbent yet highly qualified MCOs from participating. Moreover, health plans with commercial business may appear to have adequate provider networks "on paper" but will need to re-negotiate contract terms with current providers for the new Medicare/ Medi-Cal duals program; this re-negotiation may result in network deterioration. We recommend that any contracts or Letters of Intent required for a bid proposal specify that the provider will participate in the MCO's Medicare and Medi-Cal products for this program.

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

Response: Amerigroup considers itself a potential contractor for this program. Our contributions to the pilot program's success would derive from our health plans' experience with similar initiatives in other states, including managed long term care and managed LTSS programs in Florida, New Mexico, New York, Texas and Tennessee. Also, Amerigroup health plans have operated Medicare special needs plans (SNP) for dual eligibles since 2006. Our SNPs currently serve members in seven states: Florida, Maryland, New Jersey, New Mexico, New York Texas and Tennessee.

10. What concerns would need to be addressed prior to implementation?

Response: Based on Amerigroup's experience in implementing new and expanded programs in other states, we believe it is essential to have a planning process that engages all stakeholders early in the program and provides a carefully designed, deliberate transition process. Key stakeholders include community- and faith-based organizations, providers, eligible members/families with disabilities and chronic conditions, advocacy groups, legislators and even staff in other related state agencies (e.g., the Dept. of Managed Health Care). All stakeholders should participate in and be well informed of program decisions and be able to contribute to program development and ongoing operations.

Relationships with community and faith-based organizations, members/families/caregivers, advocacy groups, and providers are essential to success, achieving program goals and improving the overall health status for members and the communities where they reside. These relationships should be established early during program design and maintained throughout the duration of the contract to continually provide oversight and monitoring of the program.

A good example of engaging stakeholders early in the development of a new program is the Tennessee CHOICES program. During the initial stakeholder process, the state TennCare program examined a variety of LTSS delivery system options to achieve its overall goal of improving access and choices for individuals needing LTSS. State staff worked with existing MCOs providing managed acute care services through the TennCare program, as well as other stakeholders, to design a program that effectively diverted nursing home placement to an expanded program of home and community based services (HCBS). Stakeholders helped build strong member protections in the CHOICES program. Tennessee is one of the few states with experience in integrating all services, including behavioral health, into managed care.

Another essential element of effective program design is assuring collaboration and engagement of the provider community. It is in the intersection of quality and cost improvement where the State can realize the maximum benefits of an integrated program for dual eligibles, as well as participating providers and the State of California. Through effective provider collaboration, national MCOs with experience managing integrated programs in other states can deploy the experience gained in other markets to bring tested, best practices to positively effect the transformation of healthcare delivery.

11. How should the success of these pilots be evaluated, and over what timeframe?

Response: We suggest that the DHCS evaluate the integrated duals program pilots on a number of key success factors, including consumer satisfaction, access to care and meaningful indicators of care integration. Such indicators would include how well the contracted MCO handles discharge planning from a Medicare acute setting to ensure that beneficiaries are transitioned to a Medi-Cal community-based setting whenever appropriate.

Other care quality measures assess the level of integration of Medicare and Medi-Cal services. For example, the DHCS should examine the extent to which its MCOs are able to maintain beneficiaries living in home settings with community supports as compared with rates of institutionalization in the FFS environment. MCOs could also be evaluated in terms of utilization rates and costs for key services as compared with levels for similar populations in the FFS programs.

Contractors should also be evaluated on how well they have integrated their internal systems and processes to ensure seamless health care delivery systems for Medicare and Medi-Cal services. Operational integration would include criteria such as a single call center, a single member services department, a single complaint system, a single member handbook, etc.

We note that initial data on the program pilots likely would not be available until the projects have operated for at least 18 – 24 months. As a result, the success of pilot programs would have to be reviewed after two to three years. Financial success of the pilot should also be evaluated in terms of savings from the integrated program as compared with baseline costs from the FFS program.

12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

While DHCS could consider many approaches to rate setting and risk sharing, we would recommend that DHCS adopt a full risk model, which would entail transferring all of the health care delivery risk to the contracted MCOs. This is the approach used by CMS in the Medicare Advantage program for Part A and Part B of Medicare. Although Medicare provides a risk share arrangement within Medicare Part D prescription drug coverage, this would be optional for DHCS (it's necessary for Part D due to the significantly lower premiums and hence greater relative risk transferred to contracting plans). DHCS could consider requiring contracting MCOs to acquire reinsurance to protect themselves against large catastrophic claims.

We would suggest that DHCS consider using the CDPS risk adjustment model developed by UCSD for adjusting payments to the plans. CDPS was originally developed for chronic ill populations and has been used by a number of state Medicaid agencies to risk-adjust payments for ABD populations. DHCS would develop an overall risk adjustment factor for each MCO across its entire membership. This plan-wide

factor could be updated once or twice a year. Alternately, DHCS could consider adopting the HCC risk adjustment methodology used by CMS in Medicare Advantage. While this has the advantage of being developed specifically for a Medicare population, it has the disadvantage of being applied at the individual member level, rather than at the plan level. With the HCC model, DCHS would need to re-compute rates paid to each MCO each month; this could be a difficult process to implement. If DHCS decides to include any long-term care or HCBS services in the MCO capitated benefit package, neither CDPS nor HCC risk adjustment should apply to those services.

DHCS should use an actuarially-sound rating process such as the one currently used in Medi-Cal managed care. In the context of this dual eligible pilot program, the most significant issue facing the rate development process will be obtaining the historical medical expenditures under Medicare for these members. For the first year of this program, the State's actuaries could elect to base the medical expense estimates for Medicare-covered Part A and B services on the corresponding Medicare benchmark rate for each county, adjusted to reflect the expected risk scores of dually-eligible Medicare members (which are typically higher than non-dual Medicare beneficiaries). Pricing the prescription drug portion will require the use of an actuarially-sound prescription drug pricing model, but these have been widely developed and refined for use in the Part D bidding process.